Kansas Department of Health and Environment
Health Occupations Credentialing
Information Inventory

For Agency Use Only	License #	Issue Date	Renewal Date	Expiration Date

In order to obtain demographic information concerning health professionals licensed by Health Occupations Credentialing, Kansas Department of Health and Environment, all applicants are required to complete this inventory. Please print or type your responses.

► **Please Indicate Profession(s)**:

☐ Adult Care Home Administrator ☐ Dietitian ☐ Speech-Language Pathologist ☐ Audiologist

Name _____
Last (Gen ID) First ML Other Last Name Used

Social Security Number _____ Date of Birth ____/____/____

Mailing Address _____
Street PO/Box Apt. #

_____
City County State Zip+4

Residence State _____ Zip+4 _____

Federal Provider ID number (*if applicable*) _____

Phone (work) _____ (Home) _____

Where applicable, place the letter that corresponds with your answer in the blank and provide additional information as requested.

_____ Race
a. Caucasian
b. African American
c. Native American or Alaskan Native
d. Asian or Pacific Islander
e. Other _____

_____ Are you of Spanish origin?
Y. Yes
N. No

_____ Sex
M. Male
F. Female

_____ Highest degree held
a. High school diploma or GED
b. Nursing school diploma
c. Associate Degree
d. Baccalaureate Degree
e. Masters
f. Ph.D.
g. Education specialist
h. Ed.D.

Educational Institution granting your terminal degree _____

_____ Are you now, or have you ever been licensed in this profession in other states?
Y. Yes. If yes, list states and year granted _____
N. No

_____ Date initial license granted in Kansas.

_____ Are you now, or have you ever held an other professional license(s) issued by Kansas or any other state or entity?
Y. Yes. If yes, list license(s), state(s), or entity _____
N. No

_____ Employment status
a. Employed full-time in licensed profession
b. Employed part-time in licensed profession
c. Other related field (specify) _____
d. Other profession (specify) _____
e. Not employed (Do not answer any further questions. Sign and date inventory and return.)

If applicable, please indicate for your occupation:

Specialty _____
Concentration _____
Level _____

The Arrangement that best describes your primary and secondary employment type:

_____ Primary
_____ Secondary

a. Self-employed (own practice, partnership, consultant)
b. Employee (federal, state or local government, includes public schools, adult care home or hospital district)
c. Employee of for profit company
d. Employee of private non-profit organization
e. None

What is your primary place of practice?

_____
Facility/Setting/Institution/Agency

_____
Address City County State Zip+4

Please list the secondary and tertiary practice locations:

City County State Zip+4

Secondary _____
Tertiary _____

Dietitians and Speech-Language Pathologist or Audiologists, please see Occupational Addendum for additional locations.

Use number from list below to indicate place of practice then indicate type of function in each place of practice. If you function in more than one position in the place of practice, indicate those functions in columns 1, 2, and 3, as needed; indicate hours allotted to that function each week. Total number of hours in each place of practice must total an average working week.

Place of Practice

1. Residential Care Home
2. Hospital
3. Government Agency Federal, State, County, City
4. Community Agency
5. Home Health Agency
6. Physician's Office
7. Clinic
8. Outpatient Rehab Ctr.
9. Private Industry
10. Educational Facility

Type of Function

1. Consult
2. Clinical
3. Management
4. Educator
5. Other

Rank of Practice	Place of Practice	% of time	1. Type of Function	Estimate hours per week	2. Type of Function	Estimate hours per week	3. Type of Function	Estimate hours per week
Primary								
Secondary								
Tertiary								
Other								
Totals		100%						

I hereby attest that the information supplied is this inventory and addendum is accurate and complete to the best of my knowledge.

_____ _____
Applicant's Signature Date

Return completed inventory and addendum to:

Health Occupations Credentialing
Curtis State Office Building
1000 SW Jackson, Suite 330
Topeka, Kansas 66612-1365

OCCUPATIONAL ADDENDUM
DIETITIAN

The following questions are specific to your field of practice. Please answer these items and return this addendum with the completed Information Inventory.

_____ NUMBER OF YEARS IN PRACTICE AS DIETITIAN

_____ DO YOU HOLD A CERTIFICATE ISSUED BY THE KANSAS STATE BOARD OF EDUCATION?
y. Yes
n. No

_____ DO YOU HOLD AN EARLY CHILDHOOD ENDORSEMENT ISSUED BY THE KANSAS STATE BOARD OF EDUCATION?
y. Yes
n. No

_____ DO YOU HOLD A CERTIFICATE OF CLINICAL COMPETENCE?
y. Yes (specify)_____ Year Granted_____
n. No

_____ ARE YOU A MEMBER OF THE AMERICAN DIETETIC ASSOCIATION?
y. Yes
n. No

_____ ARE YOU A MEMBER OF THE KANSAS DIETETIC ASSOCIATION?
y. Yes
n. No

Please list other locations of practice as a dietitian not previously listed.

City	County	State	Zip #

IF PRACTICING IN A HOSPITAL, INDICATE THE NUMBER OF LICENSED BEDS AND HOURS WORKED PER WEEK

BEDS: a. Hospital #1_____ b. Hospital #2_____ c. Hospital #3_____
d. Hospital #4_____ e. Hospital #5_____ f. Hospital #6_____

HOURS: a. Hospital #1_____ b. Hospital #2_____ c. Hospital #3_____
d. Hospital #4_____ e. Hospital #5_____ f. Hospital #6_____

IF PRACTICING IN A NURSING HOME, INDICATE THE NUMBER OF LICENSED BEDS AND HOURS WORKED PER WEEK.

BEDS: a. Nrsng Hm #1_____ b. Nrsng Hm #2_____ c. Nrsng Hm #3_____
d. Nrsng Hm #4_____ e. Nrsng Hm #5_____ f. Nrsng Hm #6_____

HOURS: a. Nrsng Hm #1_____ b. Nrsng Hm #2_____ c. Nrsng Hm #3_____
d. Nrsng Hm #4_____ e. Nrsng Hm #5_____ f. Nrsng Hm #6_____

OVER

IF PROVIDING CLINICAL SERVICES, ESTIMATE, TO THE BEST OF YOUR ABILITY, THE PERCENTAGE OF CLIENTS FOR WHOM YOU HAVE PROVIDED CLINICAL SERVICES IN THE FOLLOWING AGE RANGES WITHIN THE LAST 12 MONTHS.

_____ % Newborn through 2 years

_____ % 3 years through 4 years

_____ % 5 years through 9 years

_____ % 10 years through 14 years

_____ % 15 years through 19 years

_____ % 20 years through 29 years

_____ % 30 years through 49

_____ % 50 years through 64 years

_____ % 65 years through 74 years

_____ % 75 years through 85 years

_____ % 85 years and over

_____ % Not Applicable (not providing clinical services)

_____ NUMBER OF MILES DRIVEN PER WEEK TO AND FROM HOME TO WORK

I hereby attest that the information supplied in this inventory and addendum is accurate and complete to the best of my knowledge.

_____ _____

Applicant's Signature Date

Return completed inventory and addendum to:

Health Occupations Credentialing
1000 SW Jackson, Suite 200
Topeka KS 66612-1365
(785) 296-0061

A:\Dietitian Information Inventory.wpd (bkn)